DeForest Area School District
DeForest, WI 53532

PERMISSION TO OBTAIN AND RELEASE INFORMATION

(Name of Student) _____ (Date of Birth) _____

(Street Address) _____ (City, State, Zip Code) _____

☐ **DISCLOSURE TO DEFOREST AREA SCHOOL DISTRICT**. I authorize [name, address and phone of person or organization releasing information]

_____

_____

to disclose the information indicated below, by any means (including both written and oral communication), to [name, address and phone of school official] _____

☐ **DISCLOSURE BY DEFOREST AREA SCHOOL DISTRICT.** I authorize the DeForest Area School District to disclose the information indicated below, by any means (including both written and oral communication), to:

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Phone:_____ Phone:_____

Information to be released [check all that apply]:

Education Records	**Dates of Service:**	**Health Records**	**Dates of Service:**
☐ Progress records	_____	☐ All (or specify below)	_____
☐ Behavioral Records	_____	☐ Specific records (describe)	_____
☐ Pupil Physical Health Records	_____		_____
☐ Special Ed. ☐ **All**	_____		_____
or as follows ☐ IEPs	_____		_____
☐ Evals.	_____		_____
☐ Social Work	_____		_____
☐ Other _____	_____		_____

Purpose(s) of Disclosure:

☐ Educational Evaluation and Programming
☐ School Related Health Planning
☐ Medical Evaluation and Treatment
☐ Request of Pupil or Parent/Guardian
☐ Transfer of Education Records
☐ Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be used or disclosed---I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department or school

Right to Receive Copy of this Authorization---I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to refuse to sign this Authorization---I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this Authorization---I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department or school. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Statues 118.25(2m)(a)(b) and 146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

As evidence by my signature, I hereby authorize disclosure of records to the person(s) or agency specified above.

SIGNATURE – If Pupil is a minor, for Parent, Guardian or Other Person Legally Authorized to Consent to Disclosure, state relationship to Pupil **Date Signed**

_____

SIGNATURE – Minor Pupil (only if legally required) **Date Signed**

Form Revised 6-16-18 jsh/psd